

SAVE THE CHILDREN/HONDURAS

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Child Survival 9 Final Evaluation Honduras

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ACRONYMS

AR1	Acute Respiratory Infection
ASCH	Save the Children Association/Honduras
BCG	Tuberculosis Vaccine (Bacillus Calmette-Guerin)
CDD	Control of Diarrhea] Disease
CESAMO	Health Center with Medical Staff
CESAR	Rural Health Center
CMF	Community Medication Funds
CODECO	Community Development Commission (Patronato)
CODM	Municipal Development Committees
CORU	Community Oral Rehydration Unit
DIP	Detailed Implementation Plan
DPT	Diphtheria/Pertussis/Tetanus Vaccination
EPI	Expanded Program of Immunization
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
KPC	Knowledge, Practices and Coverage Survey
MOH	Ministry of Health
MTE	Mid-Term Evaluation
NGO	Non-Governmental Organization
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
SCM	Standardized Case Management
SC/US	Save the Children/United States
SDU	Service Delivery Unit
SSS	SugarSalt Solution
USAID	United States Agency for International Development
VHW	Volunteer Health Worker
WHO	World Health Organization

ACKNOWLEDGMENTS

Special acknowledgment to the ASCH promoters and to the team at the office in Tegucigalpa for their collaboration and support. We acknowledge the great effort and love they put into their work, as well as the dedication and time they invested in it.

A smile on the face of each child whose living and health conditions have been improved is the ultimate reward for all concerned.

I. EXECUTIVE SUMMARY

This is the Final Evaluation Report of a Child Survival Project implemented by ASCH, upon completion of four years of USAID-financed work and prepared according to the 1996 guidelines for final evaluations. the time period applicable to this work.

The evaluation was conducted by an external consultant and supported by an SC/US (Save the Children/United States) representative. who remained in Honduras for a period of two weeks. during which time the evaluation team visited ASCH's areas of influence.

The evaluation methodology was similar to the one used in the mid-term evaluation, using in-depth interviews of Health Secretariat representatives at different levels. health volunteers. and representatives of the communities in which ASCH is working. Results of the knowledge. practices and coverage (KPC) survey conducted the week prior to the evaluators arrival. results of the health services survey conducted during the first week of the evaluation, and results of an internal evaluation of a group of volunteers were analyzed and preliminary observations were presented to the ASCH team and to some of the representatives of the Health Secretariat.

For most of the indicators considered in the KPC survey, positive advances of the work done by ASCH and coordination with the corresponding levels of the Health Secretariat were observed. On the other hand. although there is a slight advance. the indicators used in the survey for health facilities are far from reaching the planned targets.

ASCH's main achievements refer to stability. supervision. and training of health volunteers. and to the favorable influence on children's health that has been accomplished in the community. The experience of the Community Medication Funds is a very positive one and will be replicated at the national level.

The "centers for excellence" requires more effort and is the slowest developing activity.

Regarding the transfer and sustainability of ASCH's actions. progress has been less than spectacular. probably due to a general feeling among ASCH's staff. in the community. and in other related institutions. that the Child Survival Project will continue in the future. an aspect which is commendable.

II. INTRODUCTION

Save the Children Association /Honduras (ASCH) has completed a four-year cycle of work on child survival activities under USAID financing.

The initial three-year proposal was prepared with the general objective of “reducing mortality and morbidity of children under the age of five and fertile age women through: strengthening community groups, training families in behaviors to protect children’s health, and strengthening the preventive services of the Ministry of Health”. The proposal was extended for an additional year. The fourth year was dedicated to the continuation and consolidation of the activities, following, as much as possible, the recommendations of the mid-term evaluation (August 1995).

ASCH is implementing several projects in the areas of intervention, giving rise to numerous tasks and activities. These projects and activities offer a response to the many community needs and, because the aim is to achieve an integrated development, community participation is essential. One of these projects is Child Survival. The separation of this component from the others is a difficult task, since it is integrated in community life and, in practice, the projects and tasks depend upon and somehow support one another. Another difficulty lies in attempting to focus the final evaluation from the perspective of ASCH's child survival activities coming to an end, since ASCH will be continuing its work.

The main activities carried out by ASCH are: 1) reproductive health (including maternal health and family planning), and 2) health for children younger than five (including control of diarrheal diseases, acute respiratory diseases, immunization, and nutrition). In addition, under the concept of integrated development for the communities, there are activities related to agriculture, education, environmental sanitation, medication funds, access to credit, etc.

The **objectives** of the final evaluation were:

- A. Review the activities, interventions, achievements and lessons learned from the Child Survival Project
- B. Evaluate the degree of sustainability of the interventions

The following participants were responsible for the evaluation:

- Dr. Dilberth Cordero Valdivia, Evaluation Coordinator
- Karla Percy, Save the Children/El Salvador, representative of SC/US Home Office

Local Support was provided by:

- Dr. Luis Améndola
- Mariano Planells
- Rito Rodriguez
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- Sonia Buezo
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- Luz Patricia Molina
- Adela Flores
- Geraldina Licon
- Mirtha Raudales

III. METHODOLOGY

In order to respond to the objectives, and based upon prior experience (baseline survey and mid-term evaluation), it was decided to maintain the methodologies of information gathering previously applied, justified by the need to obtain information for comparisons. Methodologies used were:

a. Bibliographic review of existing information:

The mid-term evaluation (MTE) was the main consultation document. Formats, training materials, reports, PROMIS system, etc., were reviewed at the work areas. In addition, the baseline survey, implementation proposal, project objectives, etc. were reviewed in Tegucigalpa.

b. Interviews with groups and individuals:

- Some NGO's (i.e. PRODIM, FIO)
- Health Secretariat personnel (HS) at various levels (central, area, hospitals, CESAMOS and CESARES)
- Volunteers of the three impact areas (between 8 and 10 per area)
- ASCH promoters working in the three areas, and regional chiefs
- Community organization representatives (CODECOS/Patronatos)
- Some Community Medication Funds and an excellence center were also visited.

and the people in charge interviewed.

c. Knowledge, Practices and Coverage Survey (KPC):

Based on guidelines developed by Johns Hopkins University, the KPC Survey was conducted two weeks prior to the arrival of the evaluation team. This survey involved visits to 301 families, selected from 30 conglomerates. All three Child Survival Project impact areas were included. The results, presented within this report, represent a global analysis of the three areas. The questionnaire is presented in Appendix D.

d. Health Services Quality Survey:

The basis for the services survey was the WHO "Health Facility Survey", which includes CDD (control of diarrheal disease) and AR1 (acute respiratory infection) [Refer to Appendix E]. This survey took place during the first five days after arrival of the evaluation team. The survey observed AR1 and diarrheal case management, posed questions to the health personnel, conducted exit interviews with the mothers, and reviewed inputs and medications. Twenty-six workers from the Ministry of Health were interviewed, and the management of 52 cases was

observed in 10 health facilities. ASCH female sectoral health promoters were in charge of the survey (See Appendix D for list of interviewers).

e. Presentation of results and feedback

During the final two days, two feedback sessions were conducted, in which the preliminary results of the KPC and service quality surveys were presented. Additionally, ASCH's child survival-related activities were analyzed (the final session was attended by the Health Secretariat from La Esperanza and San Lorenzo). The conclusions of these sessions are presented below.

IV. BRIEF DESCRIPTION OF THE IMPACT AREAS

La Esperanza, Intibucá

This area is located four hours northeast of Tegucigalpa. Activities are carried out in 21 rural communities. ASCH has an office in La Esperanza, which includes the municipalities of Yamaranguila, Intibucá, Masaguara and La Esperanza.

The city of La Esperanza and the principal towns of the municipalities are of a semi-urban type, but the majority of the households are dispersed, and are characterized by very precarious conditions (i.e. earth floors, clay brick walls, no electricity or potable water).

The area is considered to be one of the most economically depressed in Honduras, with serious health problems in general.

Tegucigalpa

The work area is located in a marginal zone, on the outskirts of the city, approximately thirty minutes from downtown Tegucigalpa. This area contains disorderly human settlements, lacking basic sanitation services and having various social problems.

Work is carried out in five communities (colonias): Villa Cristina, Villa Franca, Alemania, San Juan and, Buenas Nuevas. The local office of ASCH is far from the impact area.

San Lorenzo

San Lorenzo is characterized by intensely hot weather. It is located about two hours south of Tegucigalpa. Work is carried out in 21 communities in this zone, dealing with many and varied health problems. The Pespire Community Project in this region is one of the achievements which inspired the adoption of the ASCH model by other community organizations.

V. RESULTS

A. Project Accomplishments

Measurement of indicators to enable comparison was accomplished in the baseline survey, the mid-term evaluation and in the final evaluation. Table 1 shows the comparison between the mid-term evaluation and the final evaluation. The data gathering methodology was similar in both cases (KPC Surveys).

Table 1

Comparison of the Indicators in the Detailed Implementation Plan.
Mid-Term Evaluation vs. Final Evaluation

OBJECTIVE	MTE RESULTS	FINAL EVALUATION RESULTS	COMMENTS
IMMUNIZATION - Maintain and increase timeliness of complete immunization coverage of children under one (BCG, OPV3, DPT3, measles) at 90% - Increase TT3 coverage of women of child-bearing age from 48% to 80%	93% 77%	91% 85%	The breakdown for vaccines shows: DPT3 and OPV 3 =93.6%, MEASLES=87.1% and BCG:92%
CONTROL OF DIARRHEAL DISEASES - Increase the use of ORS and home fluids from 42% to 70% during diarrhea1 episodes - Increase appropriate food intake from 47% to 70% during diarrhea1 episodes	54% 50%	65% 58%	The expected target was not accomplished
NUTRITION - Increase from 27% to 35% mothers who exclusively breastfeed their children under the age of six months -Increase from 41% to 80% mothers who know that additional food should be given to a child at 6 months in	57% 52%	59% 64%	Both consider children under the age of 4 months In practice all children between 6 and 10 months are eating other foods

<p>addition to breast milk.</p> <p>Increase from 14% to 50% children under two who participate in a growth monitoring program 3 times per year</p> <p>60% of children whose weight is monitored will maintain their tendency of normal growth</p>	<p>62%</p> <p>49%</p>	<p>78%</p>	<p>Both consider children with a weight in the last 4 months</p> <p>It was not possible to measure this indicator</p>
<p>VITAMIN A</p> <p>60% of children under five years of age will receive two doses of Vitamin A per year</p> <p>80% of postpartum women will receive one 200,000 IU dose of Vitamin A within 1 month of delivery</p>	<p>85%</p>	<p>8440</p>	<p>83% of the children older than 6 months to 2 year olds received 1 dose of Vitamin A.</p> <p>It was not possible to obtain the result of this indicator</p>
<p>MATERNAL HEALTH AND FAMILY PLANNING</p> <p>Contraceptive usage will increase from 30 to 40%.</p> <p>-Increase # of pregnant women with 3 prenatal documented visits from 10% to 70%</p> <p>-80% of highrisk pregnant women will be referred and treated at the health center</p>	<p>34%</p> <p>100</p>	<p>360</p> <p>85.5%</p>	<p>An important achievement.</p> <p>3 or more visits were considered</p> <p>It was not possible to obtain the result of this indicator</p>
<p>ACUTE RESPIRATORY INFECTIONS</p> <p>- Increase from 55% to 75% mothers who seek appropriate treatment for children with ARI (hospital, health center, private doctor)</p> <p>-7596 of mothers with children under 2 will be able to recognize the signs and symptoms of ARI</p>	<p>54%</p>	<p>67.3%</p>	<p>Coughs were considered as criterion for defining ARI. Adding those who looked for help from a volunteer, the % is 67.3%.</p> <p>51.5% of mothers with children with ARI looked for help for rapid respiration.</p>

MALARIA -Increase from 45% to 70% mother's knowledge of transmission and prevention of malaria	65%	59%	
HIV AIDS -Increase knowledge of 3 methods of transmission and 3 preventive behaviors from 45% to 70% among adult population -Increase by 10% over baseline the # of men reporting condom use -Decrease by 10% over baseline the incidence (P) of STD cases reported at health clinics.			- 10% of mothers mentioned 3 forms of transmission. 86% of mothers knew of sexual transmission - According to the mothers, condom use by their partners is 7.9% - Data not available

Table 2 reflects the status of ASCH's Child Survival Program indicators at three points (at baseline, mid-term evaluation, and at the final evaluation). Again, the methodology for information gathering was the KPC.

Table 2

**CHILD SURVIVAL PROGRAM INDICATORS
COMPARATIVE RESULTS OF BASELINE,
MID-TERM, AND FINAL EVALUATION**

Number	INDICATOR	BASELINE	MID-TERM EVALUATION	FINAL EVALUATION
1	Initiation of breastfeeding within 8 hours of birth	77% 233/301	79% 237/300	89% 266/300
2	Exclusive breastfeeding from birth up to four months	32% 16/50	57% 27/47	59% 33/56
3	Infants fed complementary foods	9% 5/57	20% 11/54	51% 39/79

3	Persistence of breastfeeding	39% 13/33	42% 14/33	31% 13/40
5	Continued breastfeeding during diarrheal episode	81% 67/83	91% 49/55	78% 67/86
6	Continued fluids during diarrheal episode	59% 50/85	78% 45/58	80% 64/80
7	Continued foods during diarrheal episode	48% 39/82	50% 27/54	58% 43/74
8	ORT use	41% 44/107	54% 37/68	62% 59/95
22	ORS use	34% 36/107	43% 29/68	60% 57/95
23	SSS use	1% 1/107	1.5% 1/68	3% 3/95
9	Mothers seeking medical treatment for child with acute lower respiratory infection	52% 62/119	54% 51/91	23.6% 22/93
10	EPI access (by card)	96% 133/139	95% 135/142	95% 133/140
11	EPI coverage (by card)	91% 126/139	93% 132/142	94% 131/140
12	Measles coverage (by card)	90% 125/139	92% 131/135	87% 133/130
13	Vaccination dropout rate	13% 7/133	2% 3/135	1.5% 2/133
14	Possession of maternal card	15% 45/300	20% 59/300	42.8% 129/301
15	Tetanus toxoid coverage (by card)	63% 189/300	77% 231/300	76.6% 331/301
16	One or more prenatal visits (by card)	11% 33/300	20% 59/300	36.8% 111/301
16	One or more prenatal visits (by self report)	73% 200/300	88% 264/300	91% 273/301
17	Use of modern contraceptives	20% 42/205	34% 74/221	36% 83/233
18	Mothers who know how to read and write	70% 211/300	81% 243/300	79.4% 239/301

Based upon situations identified in the mid-term evaluation, a series of charts were prepared to serve as a reference framework for the development of activities oriented towards the sustainability of activities during the fourth (final) year. These charts have been used to present the achievements identified during the evaluation. It is worth mentioning again that, for the people working for ASCH, as for those working with the community and the Health Secretariat, work in the child survival area will not end, at least not in the short term.

Table 3

**SUSTAINABILITY WORK PLAN (PREPARED FOR THE FOURTH YEAR EXTENSION)
CHILD SURVIVAL XII**

A. Transfer of responsibilities to the Health Secretariat (Formerly Ministry of Health).

SITUATION IDENTIFIED	ACTIVITIES PLANNED THROUGH 09/30/97	EXPECTED RESULTS BY 09/30/97	ACHIEVEMENTS OBSERVED DURING FINAL EVALUATION AUGUST 97
The MOH has not accepted its role as supervisor of volunteers	To establish regular meetings and feedback systems between ASCH and MOH in year 3; to emphasize the role of MOH in year 4 To formalize agreements with the MOH in year 3, amend year 4 if necessary	Regular meetings held in the three impact areas 3 formal agreements with the MOH related with their role by the end of the project.	The relationship between the MOH and SAVE is smooth and effective, although the MOH realizes the importance of working with volunteers, the MOH does not have the resources to carry out the supervision with the intensity that ASCH does. Agreements are being prepared for signature in October 1997.
The referral system is not working adequately	Review the instruments in the referral system and train the staff to use it (year 3) and reinforce it (year 4)	A referral system functioning between the MOH and the volunteers	The volunteers send referrals which are not always accepted by the medical staff of the MOH. More attention has been given to the pneumonia and reproductive health referrals.
The quality and supervision systems are not uniform	To adopt the work frame "path to survival" (year 3) and reinforce it (year 4) To adopt supervision and evaluation instruments for quality services based on existing materials	ASCH and the MOH have taken action to eliminate the barriers of "path to survival" especially in ARI The quality of perception at the community level regarding attention shows an increase as of the last semi-annual survey	Global concept of "path" is not well understood, although tasks have been undertaken to improve the quality of services and in the home. Apparently the community is sensitized regarding child survival problems

B. Strengthening Health Community Support

SITUATION IDENTIFIED	WORK PLAN THROUGH 09/30/97	EXPECTED RESULTS BY 09/30/97	ACHIEVEMENTS OBSERVED IN FINAL EVALUATION AUGUST 97
<p>I. Community Volunteers</p> <p>The evaluation of health microposts in the communities has not been conducted epidemiological, administrative and costs accounting</p> <p>There are no standard protocols for visiting the homes</p> <p>Education, information and communication campaigns could be reinforced.</p> <p>The volunteers need reference materials</p>	<p>To review the epidemiological impact of the health microposts in the community beginning in year 3 and review the corresponding methodology</p> <p>To review the policy acceptance, the administrative systems and the accounting of the fund and establish improved cost recuperation systems (beginning year three and monitoring year four)</p> <p>To prepare verification lists for the volunteers and supervisors in year three, reinforce behavior in year four</p> <p>Reorient and train ASCH's staff in techniques and methodologies Reinforce in year four.</p> <p>To collect and reproduce basic support materials to aid the volunteers in health education.</p>	<p>90% of health microposts respond to the needs assessment, accessibility and epidemiology of the communities</p> <p>90% of health microposts recuperate 90% of their costs</p> <p>Project objectives are being reached as established in the DIP</p> <p>The volunteers are using basic educational materials in their work.</p>	<p>All community medication funds provide treatment for pneumonia, which has increased accessibility. Administrative management still presents problems.</p> <p>Cost recuperation will reach 100%. The control of these services still present difficulties</p> <p>Home visits are carried out on an as needed basis and with specific needs (weight, updating of vital events, etc.) There is no verification list</p> <p>Work has been done to improve the radio programs.</p> <p>The materials which the volunteers have was given to them during the training, mostly referring to pneumonia and reproductive health. They have no reference guides or appropriate materials to provide training to the community.</p>

<p>2 Child Survival Excellence Community Centers</p> <p>Need to focus the improvement of production and food security.</p> <p>Need for places in the community where child survival excellence practices can be demonstrated in various components</p>	<p>To apply the lessons learned in the LUPE Project (USAID).</p> <p>To transfer LUPE's technology to the families via community leaders who have been identified, trained and supported to use their homes and farms as demonstration centers</p> <p>To train agricultural producers in several child survival components.</p>	<p>70% of the volunteers functioning as child survival excellence community centers</p> <p>70% of agricultural producers trained have knowledge of basic child survival messages.</p>	<p>In most of the communities the process has started to create these centers. The highest category of these centers still does not exist.</p> <p>Collaborating liaison producers have been trained in child survival topics</p>
<p>3 Support to the municipalities</p> <p>Additional incentives are necessary to help ensure that the volunteers will remain in their posts after the project ends.</p> <p>17 community committees created and active</p> <p>Lack of involvement of the government with the municipality</p>	<p>To review internal policies to provide more economic and credit opportunities for the volunteers</p> <p>Implementation in years 3 and 4</p> <p>To provide the volunteers training in basic first aid in year 3, verify in year 4.</p> <p>Organization and training of the Community Development Committees (CODECO) established by the new Municipal Law.</p> <p>To support and organize the Municipal Development Committees (CODEM). Each municipality will have a health sub-committee, with representation from the MOH, ASCH and the community</p>	<p>50% of volunteers will participate in community managed banks, they will have access to credit or they will participate in an economic activity</p> <p>50% of volunteers will receive training in basic first aid.</p> <p>80% of the communities will be integrated in the CODECO</p> <p>CODEM will be active in 80% of the communities</p>	<p>The volunteers have access to credit in kind (rural zones) and to "community banks" (rural areas) 50% of volunteers have received some type of credit.</p> <p>The majority of volunteers have received training in first aid</p> <p>According to municipal law, all communities form their CODECOS. The CODECOS in Save's impact areas have received training in health topics.</p> <p>According to the Municipal Law, the CODECOS and the municipal representatives form the CODEM. ASCH is represented in the CODEMs of the areas of influence.</p>

C. Strengthening the Sustainability of the Interventions

IDENTIFIED SITUATION	WORK PLAN THRU 09/30/97	EXPECTED RESULTS BY 09/30/97	ACHIEVEMENTS OBSERVED IN FINAL EVALUATION AUGUST 97
<p>1 Acute Respiratory Infections</p> <p>Only 60% of the volunteers know two or more signals of pneumonia</p>	To train ASCH's and the MOH's staff in managing cases of pneumonia	90% of ASCH's staff and volunteers will be able to diagnose, treat and refer cases of pneumonia.	<p>All volunteers who attend the community medication centers treat pneumonia</p> <p>All of Save's promoters have been trained in management of pneumonia.</p>
<p>Only 8% of ARI cases are evaluated correctly in the health services.</p> <p>Only 30% of MOH staff have adequate knowledge on how to classify ARIs</p>	To train ASCH and MOH staff in management of pneumonia cases	90% of ASCH staff and volunteers will be able to classify ARI correctly	46% of MOH staff classify ARIs adequately
Only 13% of mothers receive adequate instructions on care taking in the home	To provide volunteers and MOH staff with time takers to count respiratory frequency, year 3 Monitor year 4	To reduce the incidence and prevalence of mortality by pneumonia	A decrease in deaths by pneumonia was observed.
The indicators used by the project to monitor evaluate ARI are inadequate	To modify the indicators used by the project according to the standards established by WHO PAHO and the national ARI program.		
25 community health microposts administer treatment for pneumonia	To designate a volunteer as an ARI specialist in communities where there is no health micropost managed by the community	<p>Each of the 47 communities will have a volunteer or a health micropost for the management and treatment of ARI cases</p> <p>25 health microposts will provide treatment for pneumonia; 90% of them will recuperate the costs through sales.</p> <p>22 volunteers will manage pneumonia cases and will recuperate costs through sales</p>	<p>The 47 communities have 51 community medication funds.</p> <p>All microposts provide treatment for pneumonia. Cost recuperation is 100% through sales</p>

IDENTIFIED SITUATION	WORK PLAN THRU 09/30/97	EXPECTED RESULTS BY 09/30/97	ACHIEVEMENTS OBSERVED IN FINAL EVALUATION AUGUST 97
<p>2 Control of diarrheal diseases</p> <p>Only 50% of the mothers continues the same food or more during recuperation</p> <p>Only 8% of MOH personnel provide adequate advice to mothers on home care taking.</p>	<p>To develop a training curriculum based on the mid-term recommendations</p> <p>To develop quarterly systems to monitor the quality of attention given to cases provided by MOH and ASCH staff and volunteers.</p>	<p>80% of ASCH volunteers and staff know how to adequately manage diarrheal cases.</p> <p>80% of the mothers will receive adequate advice on how to provide attention to diarrheal diseases at home.</p>	<p>All volunteers have been trained in management of diarrheal diseases.</p> <p>29% of the mothers receive adequate advice from the MOH staff on management of diarrhea at home. The quality of the volunteer's advice is unknown.</p>
<p>3 Nutrition and Vitamin A</p> <p>Need to increase the identification of malnourished children and their families for follow up activities</p> <p>Need to improve activities of groups interested in nutrition</p> <p>Concept of micronutrients is low although VAC coverage is high</p> <p>The updating of records should be more timely.</p>	<p>Early identification of malnourished children and training of the families in the production and preparation of foods</p> <p>To continue monitoring and growth activities To incorporate education in micronutrients (V it A, iron, iodine, fluor) in all interventions</p> <p>To update records more frequently Use the information for decision making</p>	<p>80% of the malnourished children will be treated and will gain weight</p> <p>80% of the families with malnourished children will receive training in the production and preparation of foods</p>	<p>There are no treatment guidelines for treatment of malnourishment at the community level</p> <p>Training in the production and preparation of foods is carried out with most of the community</p> <p>Record updating has received more attention, but it takes a lot of time and effort to maintain the updated records. The results are used to make decisions at the local level.</p>

IDENTIFIED SITUATION	WORK PLAN THRU 09/30/97	EXPECTED RESULTS BY 09/30/97	ACHIEVEMENTS OBSERVED IN FINAL EVALUATION AUGUST 97
4 Maternal health and family planning The training curriculum needs to be updated to include the Johns Hopkins University "golden rules".	By 03/96 the training curriculum shall be developed and verified emphasizing the danger signals To reinforce the messages throughout year 4	100% of the volunteers receive training on the new curriculum and messages. 80% of the trained volunteers will know the messages and will provide adequate advice to the mothers on maternal care and family planning	The volunteers have received training in reproductive health. There are "specialized" volunteers on the subject. The quality of the volunteers' attention is unknown.

B. Project Expenditures

In Appendix K, the September 1997 Pipeline Analysis indicates that 98.9% of the grant funds net-are spent.

VI. STATUS OF ASCH ACTIVITIES AND COMMENTS ON SUSTAINABILITY

Work with volunteers.

Working with volunteers is the most important task for ASCH. Promoters are divided into eight groups, according to "specialization" criteria. In many cases, volunteers perform more than one function. There are 176 volunteers, less than the 216 noted in the mid-term evaluation.

Principal observations were:

- Training: The volunteers have received training in the fundamental topics of child survival (diarrhea control, pneumonia, vaccines, weight) and also in recording systems, first aid, etc. Generally, the training has included practice in the health services. During the last year, training in community-based treatment for pneumonia at home has been emphasized.

- Motivation: Apparently the volunteers are motivated. They generally indicate that their reason for volunteering is to provide service to their community.

- Health services (UPS) are accepted, and many volunteers participate in monthly meetings which are convened by the health services.

- Case referrals: The volunteers, especially those in charge of treating pneumonia and reproductive health, refer patients. According to the medical staff at the referral hospitals in the area, referrals are adequate.

-Supervision: ASCH promoters are in charge of supervision. These personnel are divided into sectoralists (among which there are specialists in health, agriculture, credit and sponsorships) and generalists (those in charge of all tasks). In practice, all are generalists and they supervise volunteers among their various tasks. Although there is no rigid chronogram, supervision is carried out at least once a week. Supervision related to health usually includes reviewing records, verification of the existence of medications in the community funds, and, occasionally, accompanying the volunteers on their home visits.

-Stability: The average age of the interviewed volunteers is 3.5. The aforementioned activities may be a result of a high average number of years as volunteers.

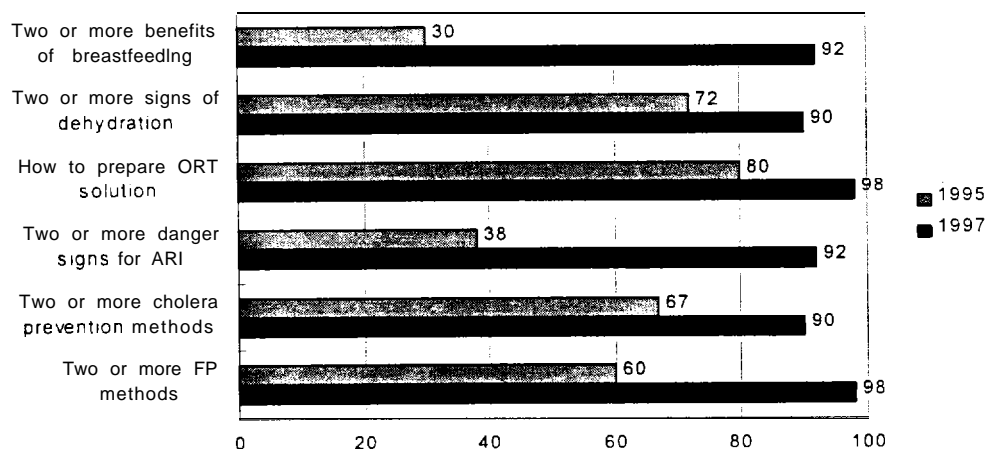
-Incentives are still insufficient: Among the interviewed volunteers there is still a subjective concept and feeling that there should be some sort of payment (generally material). Contributing to this feeling is the fact that there are other volunteers receiving economic retribution in other NGOs. ASCH has worked to promote the provision of credit in cash and in kind. To date, approximately 50% of the volunteers have received some type of credit.

-Permanent Training: Many of the interviewed volunteers have indicated a necessity- to ensure frequent training and “refreshers”. Some feel somewhat insecure in their knowledge and skills. This will require the development of a permanent feedback system.

-Quality of attention: In reality, the quality of attention provided by the volunteers is not known directly through observation of case management. ASCH carried out a new evaluation of volunteers in July 1997.

The following graphic shows the evolution of indicators comparing the above mentioned evaluation with one completed in 1995.

Comparison of Volunteer Knowledge Levels (1995 & 1997)



- Supervision by the Ministry of Health: The people interviewed at the Ministry- of Health recognize the importance of volunteer supervision, but they also recognize that it cannot happen given the scarce resources. including a lack of personnel dedicated to this task. Supervision of health personnel is occasional. and often carried out in the company of ASCH promoters.

- MOH staff and the acceptance of referred cases sent by volunteers: The acceptance of cases referred by volunteers is inconsistent and. occasionally, their referrals are totally, ignored. producing a loss of volunteer credibility. by the person who has used the referral. Counter-referrals of the health services to the volunteers is occasional.

- Volunteer relationships with communities: The volunteers are considered by their communities to be health referees and are. therefore. in demand for various health problems. They are also sought for help in gaining access to more complex systems of health services. The volunteers confront the problem of not knowing what to do in such cases. Volunteers lack support material for their discussions with the people in their communities. which would facilitate the communication of appropriate messages.

- Volunteer knowledge of role: In a manual of ASCH procedures are descriptions of some types of volunteer duties: according to the volunteers. through their interviews. these duties are not generally. known by all of them.

Community Medication Funds (CMF)

ASCH has been working with the CMFs for the past. approximately, . sis years. Their objectives are:

- To guarantee to the population access to essential . good quality. and low cost medication.
- To promote the rational use of medication.
- To promote community participation in the self-management of medication.
- To decrease self-medication.

The principal observations are:

- Presently there are 51 CMFs in the 47 ASCH communities, being managed by trained volunteers. Their training is oriented to the management of basic medication and, within the framework of child survival, to the management of pneumonia.

- In general. the function of the CMFs consists of the initial provision of approximately 15 medications (see Appendix I). which are sold at low prices. Monthly deposits of the sales profits are made. Existing supplies are reviewed monthly and necessary medications are requested from pharmacies or medical distributors. generally in the capital city. and then delivered to the CMF.

- As an incentive for the people responsible for the activity. a percentage (10%) of the sales is reserved for them as payment.

- Cost recovery is, apparently, 100%. This aspect should be studied more closely.
- The Health Secretariat showed great interest in this topic, and is considering the implementation of 300 CMFs at different points throughout the country. The experience of ASCH has been lie): to this determination. There are also regulations which provide legal status to the operation of CMFs.
- Dependence upon ASCH can still be observed in several aspects (e.g. purchase of medications). most notably, in the Tegucigalpa area.
- Rev-iew of the records in some CMFs reveals that the majority of people using them are adults. In order to adequately satisfy this demand, the list of medications must be expanded, considering the profile of the adults' pathologies, and it will be necessary to consider expansion of the training activities towards the problems observed in this population group.
- The medication sales records, balances of supplies, requests, etc.. (i.e. the administrative aspects of the CMFs) are still not functioning with the desired efficiency. This matter requires much effort and follow-up by ASCH personnel and will undoubtedly determine the sustainability of this initiatiw.

Recording and Information Systems

- Filling out of various forms is done by the volunteers, under the supervision of ASCH volunteers. Apparently,. this task presents little difficulty, as it is regularly, carried out and updated.
- All information is reviewed by the promoters in order to ensure quality. ASCH volunteers and regional staff share the information with the MOH staff, and use it to analyze health problems.
- Gathering of information pertaining to pneumonia and reproductive health is emphasized, with forms especially designed for this purpose.
- A major effort is being made to update the PROMJS data base at the regional level, but it u-ill require much work and, perhaps, the exclusive use of one person so that the updating can become an ongoing process. The program responds to some, but not all, of the information needs of the technical staff. Therefore, in order to obtain some of the information, it is necessary to export data to the EPI JNFO program, which complicates acquisition of the desired information. PROMJS is for the internal use of the institution; MOH staff is unaware of it. There is no evident advantage of the computerized system over manual records.

Coordination with the Health Secretariat (former Ministry of Health)

- ASCH's good relations with the Health Secretariat are evident.

- Coordination of work is observed at the regional level and is reflected in the activities carried out by the volunteers, vaccination campaigns, training activities, equipment, etc. At this level, it is possible to observe the sharing of information.
- Although there are no planned, formal meetings, ASCH regional personnel and their Health Secretariat counterparts meet nearly every day.
- The Secretariat's staff considers one of the principal attributes of ASCH to be its method of following and promoting national health programs.
- Since ASCH activities take place at the community level, it is unlikely that the Health Secretariat would have either the staff or resources needed to undertake these tasks (i.e. volunteer supervision), although they recognize their importance.
- ASCH assumed the management of diarrhea and ARJ in the services to be appropriate: the survey of health facilities carried out in the mid-term evaluation, however, showed this assumption to be incorrect. ASCH does not directly train medical or nursing staff, but rather depends on the Health Secretariat for this function. Nevertheless, there is interest in improving the quality of attention, such as provision of timers and other equipment to the services and support to the distance education.

Tables 4 and 5 show the results of the health services survey, using the same instrument and indicators as the mid-term evaluation.

Table 4

Principal Indicators of ARJ Program Quality

Indicator	Mid-Term Evaluation	Final Evaluation
Health staff skilled in the standard treatment of ARI cases	35% 23/43	62% 16/26
Health establishments with antibiotics available for the treatment of pneumonia	80% 8/10	100% 8/8
Health establishments which can provide standardized case management	100% 10/10	100% 8/8
Cases of ARI in which recall was conducted correctly	33% 13/40	65% 22/34
Cases of ARI in which physical examination was done correctly	23% 9/40	65% 23/34
Cases of ARI correctly evaluated	8% 3/20	47% 16/34
Cases of pneumonia which received standard treatment	30% 6/20	50% 6/12

Caretakers of children with ARI who received advice regarding home care	13% 4/30	35% 9/26
Cases other than pneumonia (cough or cold) seen at the service who received antibiotics	43% 9/21	12% 2/17
Cases of ARI who received non-indicated pharmaceuticals	25% 10/40	15% 5/34
Cases evaluated with an integrated pediatric focus	43% 17/40	26% 9/34
Health staff with adequate knowledge about ARI case classification	30% 13/43	46% 12/26
Health staff with adequate knowledge about ARI treatment	5% 2/43	23% 6/26
Health staff who know the basic advice regarding ARI management in the home	14% 6/43	62% 16/26

Table 5

Principal Indicators of C'DD Program Quality;

Indicator	Mid-Term Evaluation	Final Evaluation
Health Staff skilled in the standard case management of diarrhea	56% 24/43	77% 20/26
Health establishments with availability of ORS	100% 10/10	100% 8/8
Health establishments which can provide standard case treatment for diarrhea	100% 10/10	100% 8/8
Cases of diarrhea with correct recall	75% 9/12	83% 20/24
Cases of diarrhea with correct physical examination	67% 8/12	79% 19/24
Cases of diarrhea with correct classification of hydration status	100% 12/12	79% 19/24
Cases with correct classification of diarrhea	75% 9/12	92% 22/24
Cases of diarrhea which received inadequate antibiotics	0% 0/17	0% 0/24
Cases of diarrhea which received non-indicated pharmaceuticals	33% 4/12	25% 6/24
Cases of diarrhea in which the caretaker was correctly advised about adequate treatment of diarrhea in the home	8% 1/12	29% 7/24
Cases managed with an integrated pediatric focus	33% 4/12	67% 16/24

Health workers with adequate knowledge about recall in cases of diarrhea	68% 30/43	88% 23/26
Health workers with adequate knowledge about a physical examination in cases of diarrhea	68% 30/34	77% 20/26
Health workers with adequate knowledge about hydration	47% 20/43	73% 19/26
Health workers with adequate knowledge about intravenous hydration	16% 7/43	31% 8/26
Health workers with adequate knowledge about the use of antibiotics in diarrhea	84% 36/43	85% 22/26
Health workers who know how to manage diarrhea at home	68% 30/43	69% 18/26

Excellence Centers

Based on the experience of the LUPE Agricultural Project, the idea of Excellence Centers was extended towards health aspects.

ASCH has categorized progress in this strategy in three stages (or categories). Assuming that category three represents the model of the excellence centers, no Excellence Center could be considered as such. Table 6 shows the degree of development reached by the Excellence Centers.

Table 6

Excellence Centers According to Degree of Development

Category	La Esperanza	Tegucigalpa	San Lorenzo	Total
1	9	5	2	16
2	3	0	7	10
3	0	0	0	0
Total	12	5	9	26

Category 1 corresponds to: Existence of Community Medication Centers and two appropriate technologies for the home, farm/vegetable garden.

Category 2 Corresponds to: Existence of CMF, first aid, stretcher, and six technologies for the improvement of the home, farm/vegetable garden.

Category 3 corresponds to: Existence of CMF, first aid, stretcher, and 10 technologies for improvement of the home, farm/vegetable garden.

Improved stoves which promote an adequate elimination of smoke produced by the combustion of the firewood, resulting in important fuel savings, are among the home improvement technologies. Benefits of this technology include decreases in contamination in the home, incidence of respiratory infections, and of deforestation.

Information, Education and Communication (IEC)

There is no formally designed or implemented JEC plan. The principal experiences in JEC are those related to the communication of health messages through local radio stations. There has been an attempt to improve the technical quality of the programs; the impact of the messages has not been evaluated.

Regarding interpersonal communication, the volunteers use the materials produced by the Health Secretariat.

Relationships with other Non-Governmental Organizations (NGO's)

A meeting was held with representatives from the International Eye Foundation (JEF) and the Project for the Development of Infants and Children (PRODIM). Both of these NGO's praised ASCH's work, especially PRODIM. u-hose representative talked about the great similarity in focus of both NGOs. The principal experience common to both ASCH and PRODIM is the community medication funds activity. The JEF representative was more critical, especially with regard to the information system (PROMIS), the lack of a transferring plan, and the "perpetuation" of ASCH in the same communities for too long.

Both representatives consider that ASCH's main work is with the volunteers and they recognize the efforts and achievements reached. In addition, ASCH is the leader of an NGO network which seeks to coordinate and regulate activities throughout the country.

VII. CONCLUSIONS

General

During site visits to ASCH's areas of influence, a strong project presence was apparent, as reflected in the people, the homes, and the community in general.

Given the fact that the places where ASCH is working represent the most depressed zones in the country, the status of the indicators shows intense work and dedication. The fact that the indicators are, for the most part, higher than the national average, represents achievements based on coordinated work, especially with the Health Secretariat.

Specific

a. Volunteers

The experience of working with volunteers should be systematized, analyzed, and shared with other institutions, government or non-government, which also work with this group of people. Achieving high rates of permanence is something that should be replicated. It is necessary to conduct an in-depth study seeking the causes which motivate either stability or desertion of the volunteers. In this regard, ASCH should not only seek stability or training of a certain number of volunteers, but should also promote the quality in attending cases by the volunteers.

The specialization of the volunteers appears to be working adequately and the establishment of community management of pneumonia cases has shown a decrease in the mortality caused by this disease. This specialization might not be compatible with the “Integrated Management of Childhood Illnesses” (JMCI) strategy to be implemented in the near future in this country and which will have a health volunteer component.

Certainly, one of the determining factors for stability of the volunteers is the continuous supervision by ASCH staff. Neither the Health Secretariat nor its representatives in the area are able to maintain this intense supervision.

b. Community Medication Funds

The proposed goals have been achieved in this area and the experience has been successful, but there are still some aspects which require additional work so that they can be consolidated (e.g. administrative management). Presently, the funds could not be managed by the community because they still are very dependent on ASCH support, especially in the area of Tegucigalpa.

c. Excellence Centers

Progress in this initiative is still slow, possibly because of the rigid criteria which define an excellence center which has “graduated”, i.e. of the highest category.

d. ASCH and the Health Secretariat

The coordination achieved between these two institutions is an enviable achievement for other NGOs. This observation was verified in the conversations held with people who work at different levels of the Secretariat.

In spite of the above, and even with recognition of the importance of ASCH's tasks, it would be unrealistic for the Health Secretariat to assume ASCH's activities, at least with the same intensity. In any case, the areas in which ASCH is working would be ideal sites in which to initiate application of the JMCI strategy, which would be highly beneficial for ASCH, the Health Secretariat and, of course, children under five.

e. ASCH and the Community

The knowledge demonstrated by the indicators in the KPC survey, and by the community representatives during the interviews, reflects important information and training work done with the community and its leaders. ASCH has managed to achieve recognition of the importance of childrens' and womens' health issues. The aspects which still have not been achieved require a more systematic focus, based on an adequate IEC strategy.

An organized community should progressively assume some of the activities developed by ASCH. This proposal is promoted by ASCH when working with the excellence centers and with the medication funds, but there is still a need for external technical support.

When discussing the situation in Pespire (San Lorenzo), the case was presented as an example of how the community could create its own NGO, with a similar orientation as ASCH. This experience should be followed and could provide orientation as to how the community assumes its own development and its own health issues, thus supporting the sustainability of many of ASCH's activities.

f. ASCH and the future - final conclusions.

The final evaluation of the child survival component has been difficult, especially because the people who were interviewed were told that, while this was a final evaluation, it was not the end of child survival activities. ASCH plans to continue implementing CS activities in these areas, because more work is required before responsibilities can be phased over to local partners. This continuity is important, since a high level of commitment by the community has been achieved and excellent relations established with the Health Secretariat, key elements for an ideal framework within which to confront future challenges and achieve even higher goals.

The worldwide trend of IMCI will soon be introduced in Honduras and, as mentioned above, ASCH's areas of influence should be the starting point for the implementation of this important, comprehensive initiative.

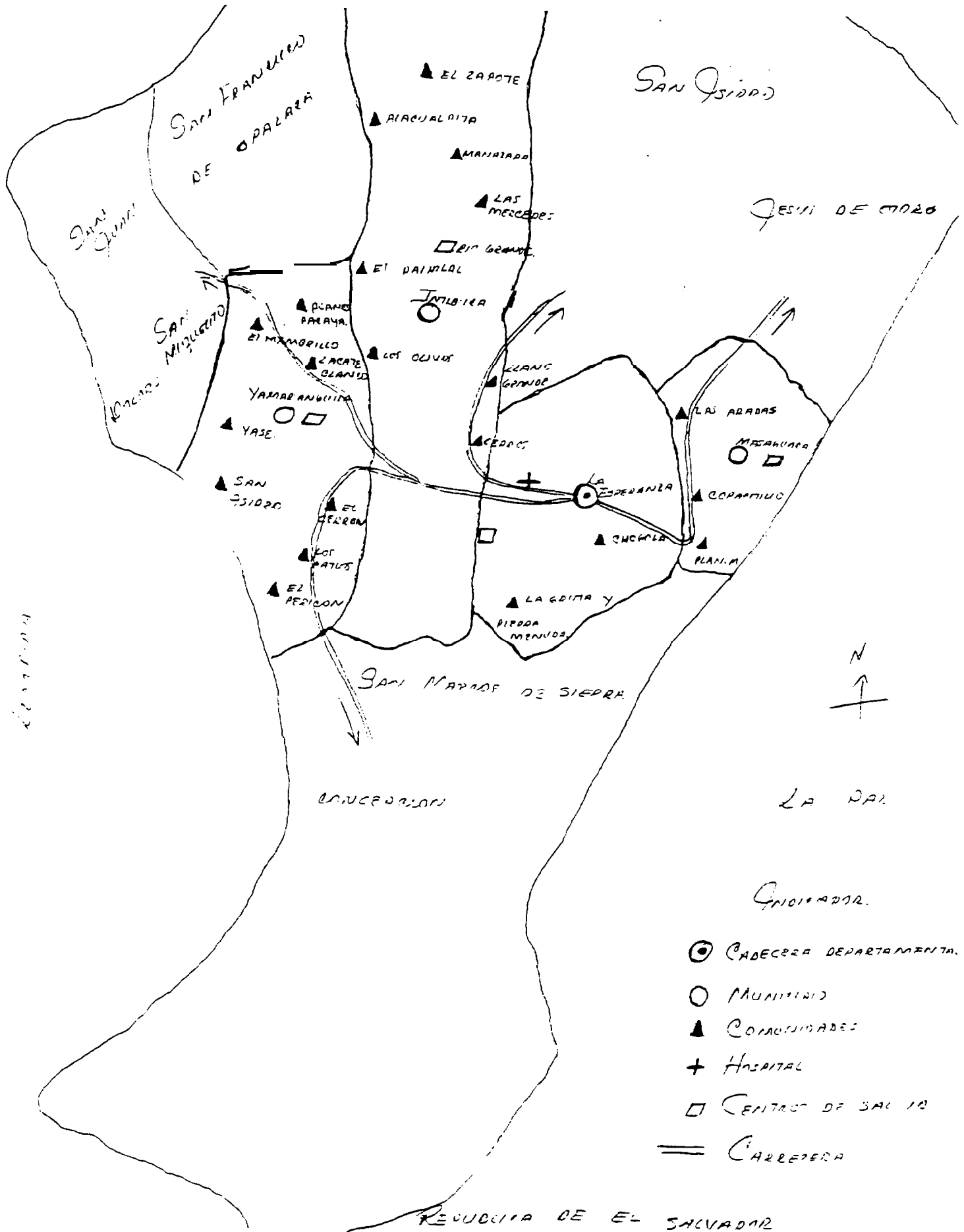
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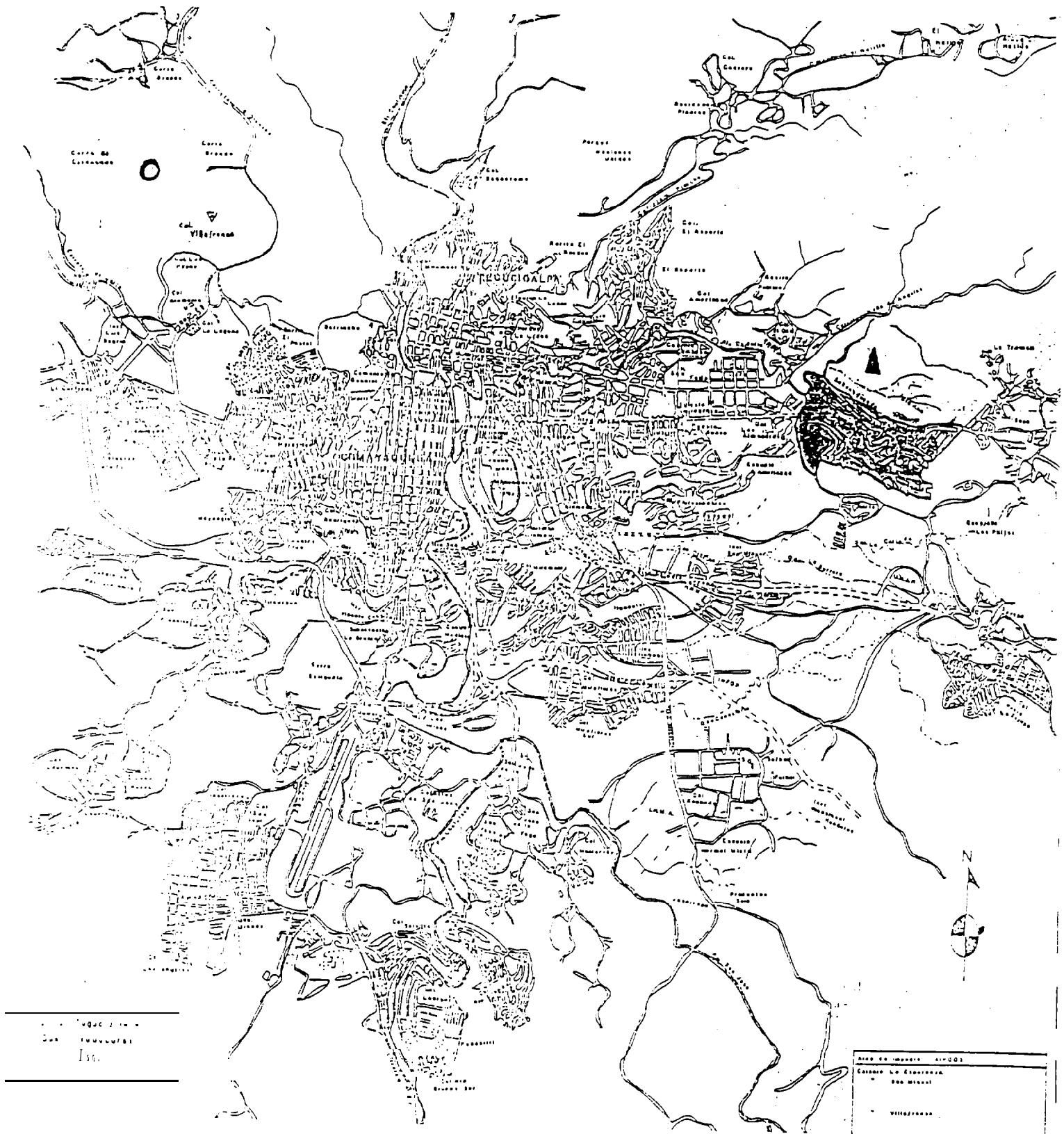
Appendix A

Impact Area Maps

AREA DE IMPACTO 02, LA ESPERANZA, INTIBUCA



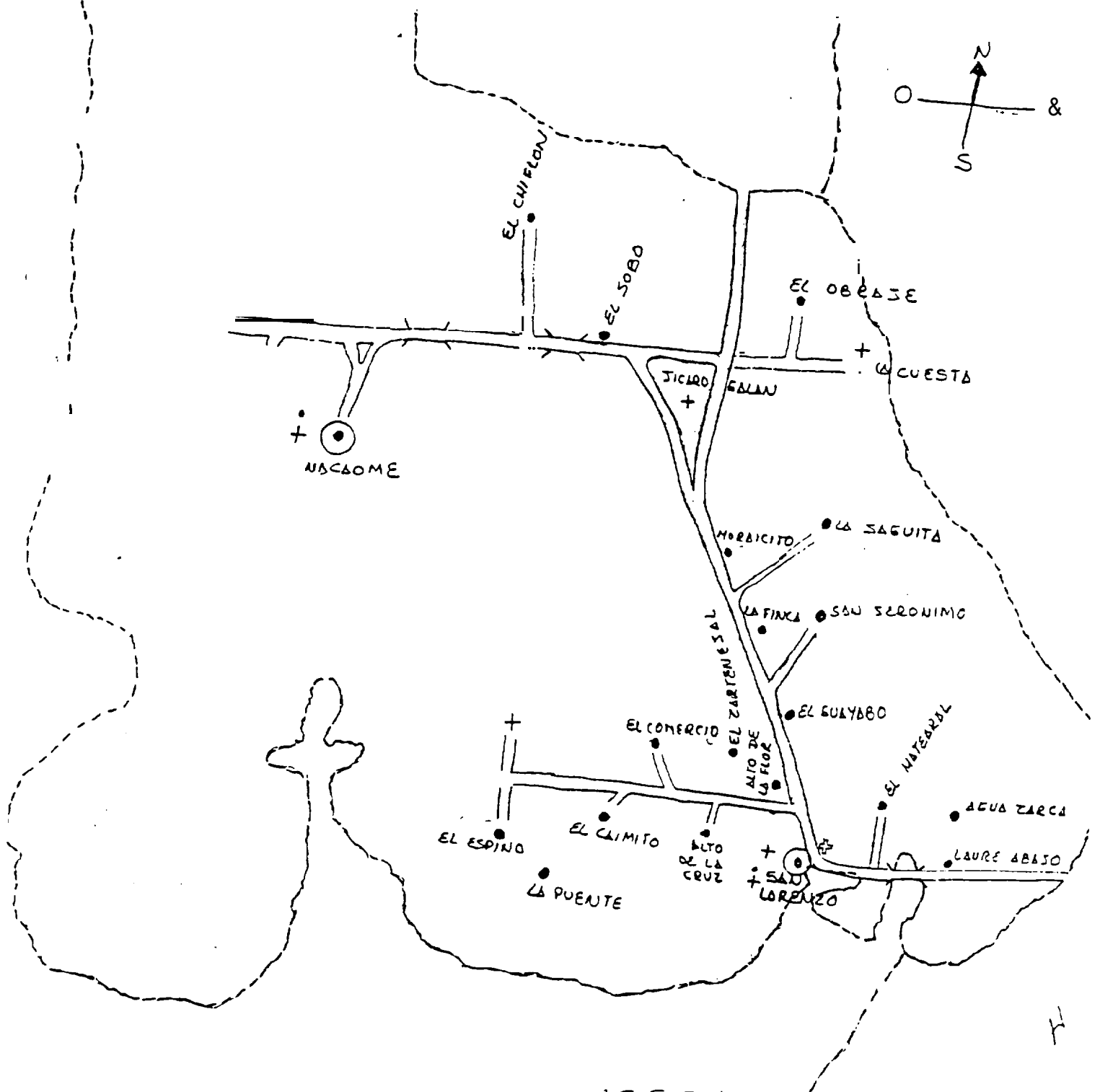
AREA DE IMPACTO 03, TEGUCIGALPA



▲ Colonias Viejas:
La Esperanza
San Miguel

○ Colonias Nuevas:
Buenas Nuevas
Alemania
Las Pavas
La Brasilia
Villafranca
San Juan del Norte
Vill3 Cristina

AREA DE IMPACTO 04, SAN LORENZO, VALLE



GOLFO DE FONSECA

+ CESAR

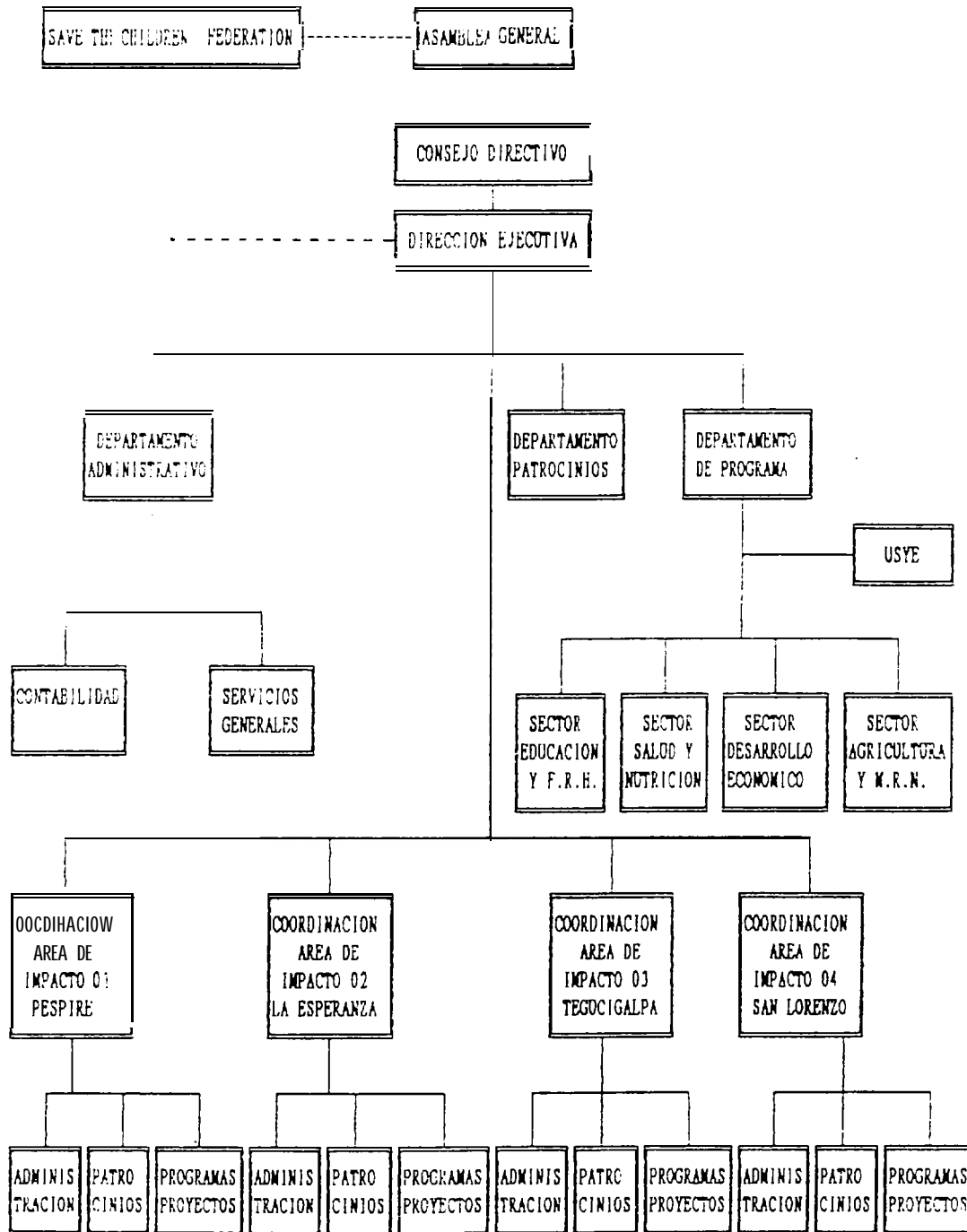
+ CESAMO

+ HOSPITAL

Appendix B

Honduras Program Organigram
Curriculum Vitae of Dr. Dilberth Cordero Valdivia

ORGANIGRAMA DE LA ASOCIACION SAVE THE CHILDREN DE HONDURAS



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Education

M.D. Facultad de Medicina Universidad Mayor de San Andrés, La Paz, Bolivia 1981-1986.

Certification

Pediatrician, Colegio Médico de Bolivia, Sociedad Boliviana de Pediatría 1992

Professional and work experience

Technical Assistant, BASICS 1994-1997. Child survival: Control of diarrhoeal diseases, cholera (1994-96); Acute respiratory Infections (1994-96); Integrated Management of Childhood Illness IMCI- (1996-97).

Pediatrician, Hospital del Niño "Ovidio Aliaga Uría". La Paz Bolivia. 1994-1995

Professor of Pediatrics, residency Program, Hospital del Niño, La Paz, Bolivia 1995-96

Surveyor, CDD, Health facility Survey, Bolivia 1995, 1996

Trainer, Clinical Trainer Center ARI/CDD, Hospital del Niño, La Paz, Bolivia 1995-97

Pediatrician, Juan XXIII Hospital. 1992-1994.

Technical advisor for development of training material for health personnel, PRITECH 1992-1993.

Chief of **pediatrics residency**, Hospital del Niño, Gestión 1991.

Health Center Director. Licoma Health Center, Provincia Inquisivi. 1989.

Junior professor of Embryology and genetics. Facultad de Medicina, UMSA 1985-1986.